(PLEASE PRINT)

Patient Information

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

Dental Registration and History

Health History

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Problems	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Hepatitis Type _____	☐ Yes	☐ No	Special Diet	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
			High Blood Pressure	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Tumor or growth on head or neck	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No			
Cortisone Treatments	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Weight Loss, unexplained	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No			

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other _____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Mission Hill Dental
Dr. Horacio Lucero
Dr. Fred B. Willard
2732 Big Oak
New Braunfels, Texas 78132

Financial Policies

PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, personal check, and all major credit cards. We require you to pay your estimated cost share at the time services are rendered. Any remaining balance will be billed to you once your insurance company has processed your claim. If any amount is left unpaid and collection fees are incurred, these additional fees will be added to the patient's account balance and become the responsibility of the patient or guarantor on the account.

If you have insurance coverage, the insurance information must be supplied at the time of service. We will file up to 2 insurance claims, primary and secondary, as a courtesy for you. **You are responsible for any non-covered items or services. Not all services and supplies are covered by insurance. If you are not clear on the coverage and benefits of your plan, please call your insurance company to inquire what your out of pocket expenses will be for the services you receive.** Your policy is between you and your insurance company and coverage varies per policy, we cannot be involved in disputes over non-covered services or supplies. If your insurance has not paid our claim within 45 days from the date of service, we ask that you call your insurance company to expedite payment. After 60 days of non-payment, you will become responsible for the balance.

CANCELLATION POLICY: Please give 24 hour advanced notice if you are unable to keep an appointment so that we may open a slot for other patients in need. Failure to do this will result in a $55 cancellation fee.

Please read and sign:
I will be responsible for any supplies or services which are provided to me.
I have been provided an opportunity to review the Notice of Privacy Practices regarding this office's HIPPA compliance. I also have read the financial and cancellation policies listed above and agree to these terms.

Print Patient Name:_____

Patient Signature (Guarantor if a minor):_____ Date:_____

Mission Hill Dental Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMTION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

· basis for planning your care and treatment
· means of communication among the many health professionals who contribute to your care
· legal document describing the care you received
· means by which you or a third party payer can verify that services billed were actually provided
· a tool in educating health professionals
· a source of data for medical research
· a source of information for public health officials charged with improving the health of the nation
· a source of data for facility planning and marketing
· a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

· ensure its accuracy
· understand who, what, when, where and why others may access your health information
· make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that complied it, the information belongs to you. You have the right to:

· request a restriction on certain uses and disclosures of your information
· obtain a paper copy of the notice of information practices upon request
· inspect and copy your health record
· amend your health record
· obtain an accounting of disclosures of your health information
· request communications of your health information by alternative means or at alternative locations
· revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:
· maintain the privacy of your health information
· provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
· notify you if we are unable to agree to a requested restriction
· accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I, _____ have received a copy of Mission Hill Dentals
(Name of Patient)

Notice of Privacy Practices.

_____
(Signature of Patient)

Date:_____

For Office Staff Only

To be filled out if patient's signature not obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notices of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situations kept us from obtaining the patient's signature.

_____ Other

MISSION HILL DENTAL

Dr. Horacio Lucero
Dr. Fred B. Willard
2732 Big Oak, New Braunfels, TX 78132
830-625-7322 Phone
830-620-5709 Fax
www.missionhilldental.com

Dr. Lucero, Dr. Willard and/or their staff will not release dental information to or discuss dental information with anyone except the following people listed below unless permission is given in writing.

Name:	Relationship to patient:	Phone number:
Name:	Relationship to patient:	Phone number:
Name:	Relationship to patient:	Phone number:

Notice of Privacy Practice:

I hereby acknowledge that I have been presented with a copy of Dr. Lucero and Dr. Willard's Notice of Privacy Practice and that I have read and understand my rights.

_____ _____

Signature of Patient or Legal Guardian if patient is a minor Date